

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRARDECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

MARY

Loleta

Andrew

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

11-24-87

2:47 P.M.

3. SEX

Female

4. RACE

Caucasian

5. DATE OF BIRTH

MONTH

DAY

YEAR

Nov. 12, 1901

6. AGE (IN YEARS LAST BIRTHDAY)

86

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE  
(STATE OR FOREIGN  
COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U. S. A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Tolbot

MD.

10. CITY OR TOWN OF DEATH

Easton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Memorial Hospital

12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Housewife

12b. KIND OF BUSINESS OR  
INDUSTRY

Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Caroline

13c. CITY OR TOWN

Denton

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

Denton-American Corner Rd

21629

14. FATHER'S NAME

John

MIDDLE

Lee

LAST

Chance

15. MOTHER'S MAIDEN NAME

Anna

MIDDLE

Matilda

LAST

Pinder

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

219441817

17. INFORMANT

ADDRESS

A. Curtis Andrew, Denton, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MINUTES

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (a) (this hospital) attended the deceased from Feb 1969 to 11/24 1987 that (b) (we) last  
saw the deceased alive on 7/27 1987, and that in (c) (our) opinion death occurred on the date and hour and from the causes stated  
above, (d) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING  
PHYSICIANMEDICAL  
DIRECTOR ☒STAFF  
PHYSICIAN ☐

22c. DATE SIGNED

11/24/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Ludwig J. Eglseder III MD

22e. ADDRESS

RT 3, Box 106, Easton Md 21601

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

11/28/87

23c. NAME OF CEMETERY OR CREMATORY

Concord Cemetery

23d. LOCATION  
CITY OR TOWN

Denton

COUNTY

STATE

MD

24. FUNERAL DIRECTOR

NAME

Moore Funeral Home

ADDRESS

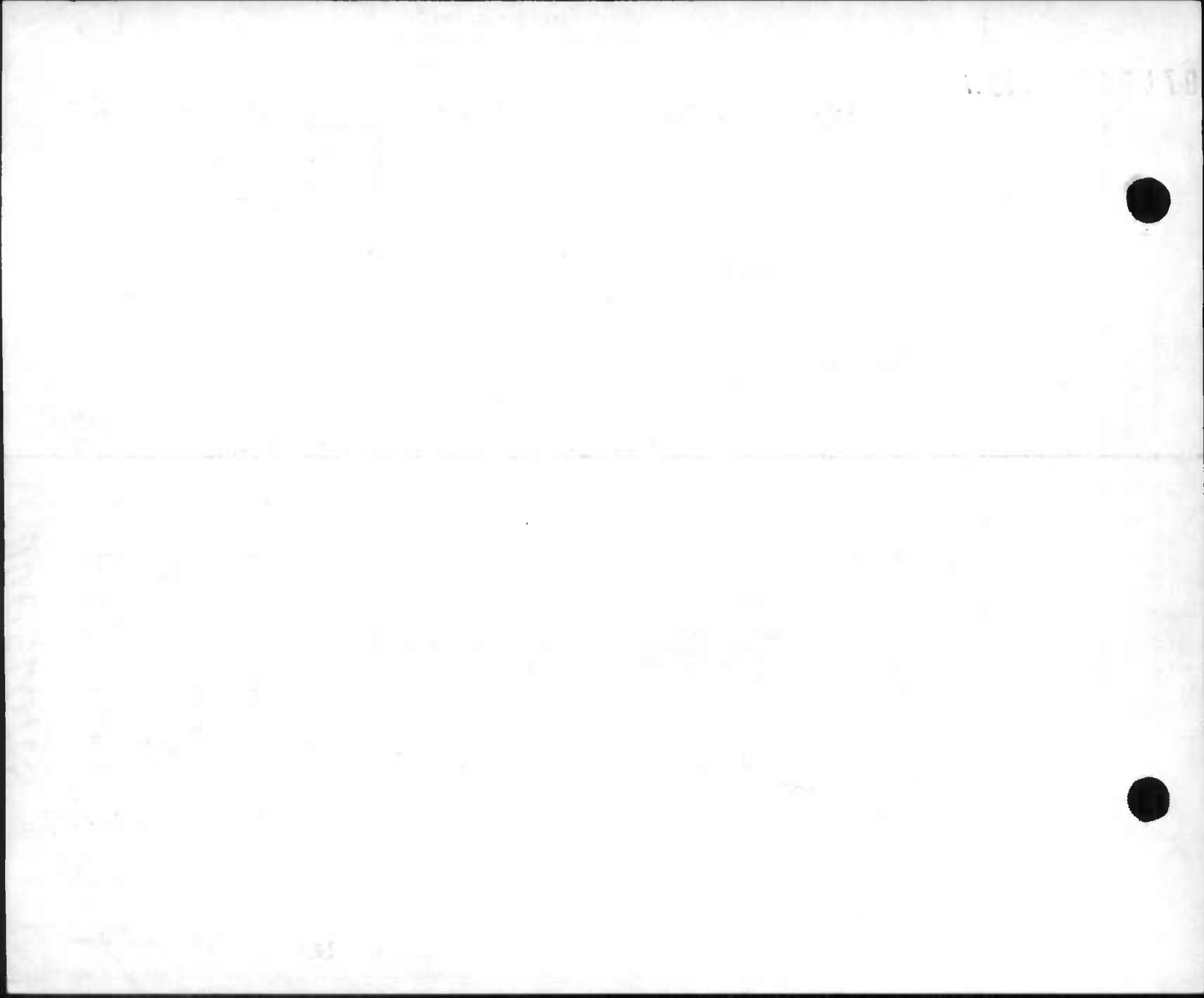
Denton, Md.

25. DATE REC'D. BY REGISTRAR AND REGISTRAR'S SIGNATURE

DEC 07 1987

Julia Benson-Budala

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the funeral director. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.



071903 NOV 16 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 3 3 5 2 0

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Daniel James Ball Jr.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>November 6, 1987</i>		2b. HOUR M <i>10:30</i>				
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>07 31 15</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>72</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD.			
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Waterman</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Seafood</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Neavitt</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>Manor Road</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Daniel James Ball Sr.</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Carroll Harrison</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>220-16-9246</i>		17. INFORMANT ADDRESS <i>W Glenn Ball 810 N Washington St Easton MD</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Probable sepsis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hours</i>	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pseudomembranous enterocolitis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Probable antibiotic therapy</i>								<i>days</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <i>S/P suprapubic prostatectomy for adenocarcinoma</i>									
19a. DATE OF OPERATION <i>11/6/87</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>adenocarcinoma</i>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Reinhardt Sahmel MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <i>11/6/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Reinhardt Sahmel MD</i>				22e. ADDRESS <i>LAB Memorial Hospital Easton</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11/10/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Neavitt Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Neavitt Talbot MD</i>			
24. FUNERAL DIRECTOR NAME <i>Newnam Funeral Home</i>				ADDRESS <i>Easton, Maryland</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 13 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

110011011



071991 NOV 17 07

FOR  
- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 33521

1. DECEASED NAME (TYPE OR PRINT) <b>Andrew B. Banghart</b>			7a. DATE OF DEATH MONTH DAY YEAR <b>11 - 12 87</b>		7b. HOUR <b>2:45</b> M
1. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>08 26 12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.	
10. CITY OR TOWN OF DEATH <b>Easton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital at Easton Md</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Portrait Painter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Art/Painting</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Talbot</b>	13c. CITY OR TOWN <b>Easton</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>404 Trippe Avenue</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Byron T. Banghart</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Isabel Cushman Buckheimer</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 216-16-3389</b>		17. INFORMANT ADDRESS <b>Dorothy B. Banghart P O Box 151 Easton MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ventricular tachycardia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>arteriosclerotic cardiovascular disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>10 yrs.</b> <b>yr.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>Diabetes mellitus</b>					
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>— — — 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>—</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>— — — — —</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>19 84</b> to <b>11/12 87</b> , that (I) (we) last saw the deceased alive on <b>11/12 87</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If not, state did not view the body after death)					
22b. SIGNATURE <b>Albert T. Hawkins</b> DEGREE <b>MD</b>				22c. DATE SIGNED <b>11/12/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALBERT T. HAWKINS JR</b>		22e. ADDRESS <b>Route 5 Box 307 Easton, Maryland 21601</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>11/13/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Salisbury Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury Wicomico MD</b>	
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>		ADDRESS <b>Easton, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 10 1987</b>	
		25b. REGISTRAR'S SIGNATURE <b>—</b>			

DHMH - 16 50M 1/81  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The death certificate is to be signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The death certificate is to be signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRARDECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

BARBARA JEAN BETZ

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

11/13/87

2:30 PM

3. SEX

FEMALE

4. RACE

CAUC.

5. DATE OF BIRTH

MONTH DAY YEAR

JAN. 25, 1909

6. AGE (IN YEARS LAST BIRTHDAY)

78

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

WISCONSIN

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

9. BALTIMORE CITY OR COUNTY OF DEATH

TALBOT

MD.

10. CITY OR TOWN OF DEATH

EASTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
MEMORIAL

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)  
PHYSICIAN

12b. KIND OF BUSINESS OR INDUSTRY

MEDICAL

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MARYLAND

13b. COUNTY

TALBOT

13c. CITY OR TOWN

ST. MICHAELS

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

P.O. BOX 337 PEANECK RD. 21663

14. FATHER'S NAME

FIRST

MIDDLE

LAST

JONATHAN CLYDE BETZ

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

MARGARET MCKEE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

-----

17. INFORMANT

ADDRESS

220-30-2974A

18. CAUSE OF DEATH

(Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARCINOMA BRONCHUS

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

3 MONTHS

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/1/87, 19\_\_\_\_\_, to 11/13/87, 19\_\_\_\_\_, that (I) (we) last saw the deceased alive on 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

C. W. BAIN

DEGREE

M.D.

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

11/13/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

C. W. BAIN

22e. ADDRESS

Easton, Md. 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

CREMATION

23b. DATE

NOV. 13, 1987

23c. NAME OF CEMETERY OR CREMATORY

LEE CREMATORY

23d. LOCATION

CITY OR TOWN

CLINTON

COUNTY

P.G. MARYLAND

STATE

24. FUNERAL DIRECTOR

NAME

ADDRESS

HARRISON E. LEONARD - St. Michaels Rd.

DATE RECEIVED BY REGISTRAR

NOV 16 1987

25. REGISTRAR'S SIGNATURE

Julia Borden-Radner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked as item 18 above, any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
AND

0538000101



072415 NOV 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES ANTHONY BLANN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 14, 1987</b>		2b. HOUR <b>11:00 Pm</b>							
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 29 68</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>18</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.						
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Route 2 Box 656</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Talbot</b>		13c. CITY OR TOWN <b>Easton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt 2 Box 656 21601</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ronald Lee Blann Sr</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Betty Smith</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-92-5116</b>			17. INFORMANT ADDRESS <b>Ronald L Blann Rt 2 Box 656 Easton MD 21601</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>malignant lymphoma c</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>anasarca + bilateral pleural effusions</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11 months</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>((Burkitt's lymphoma) c widespread involvement</b>												
19a. DATE OF OPERATION <b>11/12/87</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>lymphoma</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>11/12</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>729 87 11/14 87</b>						
22a. I certify that (I) (this hospital) attended the deceased from <b>11/12 1987</b> to <b>11/14 1987</b> , that (I) (we) last saw the deceased alive on <b>11/12 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.												
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BENT T. DANKINS JR</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/16/87</b>				
22d. ADDRESS <b>EASTON 508 IDLE WILD AVE MARYLAND 21601</b>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/18/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oxford Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Oxford Talbot MD</b>					
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>						ADDRESS <b>Easton, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 18 1987</b>			25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers for pages 1 and 2, should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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NOV 18 1964

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTER

7. DECEASED NAME (TYPE OR PRINT) George R. Bullinger			20. DATE OF DEATH MONTH DAY YEAR 11-23-87			2b. HOUR 7:30 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 09 28 10		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maint Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Printing	
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 134 Chapel Road		14601					
14. FATHER'S NAME FIRST MIDDLE LAST George M Bullinger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth J. Schroeder					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-07-0012		17. INFORMANT ADDRESS Pearlie W Johnson P O Box 1824 Easton MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/20/87</u> 19____, to <u>11/23/87</u> 19____, that (I) (we) lost saw the deceased alive on <u>11/22/87</u> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C. W. Bain MD, MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/23/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. W. BAIN		22e. ADDRESS Easton, Md, 21601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/25/87		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Easton Talbot MD	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton, Maryland		25a. DATE REC'D. BY REGISTRAR NOV 24 1987	
						25b. REGISTRAR'S SIGNATURE Julia S. [Signature]	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and file with the funeral director. The funeral director should file this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

73016 NOV 25 87



**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO.

FOR  
 1 - STATE  
 REGISTRAR

DECEASED NAME (TYPE OR PRINT) <b>ETHEL ANNABEL COLE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOV. 21, 1987</b>			2b. HOUR <b>6 P.M.</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 12, 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>69</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.				
10. CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>R.D. #3, BOX 785</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>REG. NURSE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Medical</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>TALBOT</b>		13c. CITY OR TOWN <b>EASTON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>R.D. #3, BOX 786/21601</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward William Wainwright</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leslie Jones</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>			16b. SOCIAL SECURITY NO. <b>213-60-7669</b>			17. INFORMANT <b>FRANCIS C. COLE</b>			ADDRESS <b>see item 13</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**PROGRESSIVE PARKINSONS DISEASE**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**15 YRS**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
 gave rise to immediate  
 cause (a), stating the  
 underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6-14</b> , 19 <b>85</b> , to <b>11-21</b> , 19 <b>87</b> , that (I) (we) most saw the deceased alive on <b>3-3</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Stephen P. Carney</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-22-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEPHEN P. CARNEY, M.D.</b>				22e. ADDRESS <b>Dutchmans Lane EASTON, MD. 21601</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-24-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SPRING HILL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>EASTON, TALBOT, MD.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>NEWMAM FUNERAL HOME Easton, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 24 1987</b>			
				25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please replace carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.)

NOV 19 1957

NOV 24 1957

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRARDECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

1 - Eugene Francis Connolly aka E. Frank Connolly

2a. DATE OF DEATH MONTH DAY YEAR

November 9, 1987

2b. HOUR

7:20 P M

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR  
12 25 14

6. AGE (IN YEARS LAST BIRTHDAY)

73

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Talbot

MD.

10. CITY OR TOWN OF DEATH

Easton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Route 1 Box 562

12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Farmer

12b. KIND OF BUSINESS OR INDUSTRY

Agriculture

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
Maryland13b. COUNTY  
Talbot13c. CITY OR TOWN  
Easton

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

Route 1 Box 562

21601

14. FATHER'S NAME

Charles

MIDDLE

Carroll

LAST

Connolly Sr

15. MOTHER'S MAIDEN NAME

Anna

MIDDLE

Amelia

LAST

Slaughter

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

no

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

220-34-9302

17. INFORMANT

Helen K Connolly Rt 1 Box 562 Easton MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) metastatic carcinoma of rectum

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (1) (this hospital) attended the deceased from Nov 13, 19 87, to Nov 9, 19 87, that (1) (we) lost saw the deceased alive on Nov 9, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

MD

ATTENDING  
PHYSICIAN ☐MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☐

22c. DATE SIGNED

11/11/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

James C. Gieske, M.D.

22e. ADDRESS

505 Dutchman's Lane Easton MD 21601

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

11/12/87

23c. NAME OF CEMETERY OR CREMATORY

Spring Hill Cemetery

23d. LOCATION  
CITY OR TOWN

Easton

COUNTY

Talbot

STATE

MD

24. FUNERAL DIRECTOR

NAME

Newnam Funeral Home

ADDRESS

Easton Maryland

25a. DATE REC'D. BY REGISTRAR

NOV 12 1987

25b. REGISTRAR'S SIGNATURE

Julia Gordon-Parker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked ☒ item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

71809 JUN 1947



72414 NOV 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

33527

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA E. DULIN			2a. DATE OF DEATH MONTH DAY YEAR November 13, 1987		2b. HOUR 6:20 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 04 20 23		
6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.				
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		
12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Talbot		
13c. CITY OR TOWN Cordova		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt 1 Box 65 21625		
14. FATHER'S NAME FIRST MIDDLE LAST Vincent Callahan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lelia Callahan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 215-14-3289		17. INFORMANT ADDRESS C Kenneth Dulin Rt 1 Box 65 Cordova MD 21625		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>hemothorax pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>3 days</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ASVD coronary artery disease + cerebrovascular disease</u>						
19a. DATE OF OPERATION with		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>acute middle cerebral</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11/13 87 11/13 87		
22a. I certify that (I) (this hospital) attended the deceased from <u>11/13 87</u> to <u>11/13 87</u> , that (I) (we) last saw the deceased live on <u>11/13 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated						
22b. SIGNATURE <u>Robert T. Dawkins Jr.</u>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11/14/87		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT T. DAWKINS JR.		22f. ADDRESS 508 IDE WILD AVE SABON MARYLAND 21601				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/16/87		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Pk		
23d. LOCATION CITY OR TOWN COUNTY STATE Easton Talbot MD		24. FUNERAL DIRECTOR NAME Newnam Funeral Home		25a. DATE REC'D. BY REGISTRAR NOV 18 1987		
25b. REGISTRAR'S SIGNATURE <u>Julia...</u>						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on the back of this certificate, it should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 3 3 5 2 8

1 - FOR  
STATE  
REGISTRAR

REG. NO.

071544 NOV 12 1987

1. DECEASED NAME (Type or print) FIRST MIDDLE LAST <b>MABEL L. FASSETT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-16-87</b>		2b. HOUR <b>9:25 AM</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 16 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD	
10. CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>GA.</b>		13c. CITY OR TOWN <b>Groesbeek</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY LOCKWOOD</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ARDELLA LOCKWOOD</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219-03-2064</b>	
17. INFORMANT ADDRESS <b>Shirley Thomas Cemetery Rd. Groesbeek</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA's</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diffuse arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>years</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes Mellitus</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/15/87</b> to <b>10/16/87</b> that (I) (we) last saw the deceased alive on <b>10/15/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Phyllis Rhodes</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/16/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PHYLLIS RHODES, MD</b>		22e. ADDRESS <b>503 Dutchman's Ln, Easton, Md 21601</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>B</b>		23b. DATE <b>10/22/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Robinson's</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Groesbeek GA MD</b>	
24. FUNERAL DIRECTOR NAME <b>Eric Dashiell P.O. Box 606</b>		ADDRESS <b>Easton, Md 21601</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 10 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Phyllis Rhodes</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabbing papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

07134 113170

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

072009 NOV 17 87

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Melvin Fells Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 7 87</b>		2b. HOUR <b>11:06 AM</b>
3. SEX <b>Male</b>	4. RACE <b>Blk</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>05 13 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT MD.</b>		
10. CITY OR TOWN OF DEATH <b>Easton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Talbot</b> 13c. CITY OR TOWN <b>Easton</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>424 South St. 21601</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Peter Fells</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Tina FOX</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212.16.2101</b>		17. INFORMANT ADDRESS <b>Ellen Hill</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Generalized Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <b>S/P CVA. - Ch. Arteriosclerosis</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 1987</b> to <b>Nov 7, 1987</b> , that (I) (we) lost saw the deceased alive on <b>Sept 1987</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Richard J. Murrell</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>11/9/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/14/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Paradise Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY <b>Trappe Talbot MD</b>
24. FUNERAL DIRECTOR <b>George Dabill</b>		ADDRESS <b>31 JOWITE ST. Easton MD</b>		25a. DATE REC'D BY REGISTRAR <b>NOV 16 1987</b> 25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

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NOV 10 1987

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 33530

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Ryda Rose Fuchs</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 7 87</b>			2b. HOUR <b>8:56 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 5, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>63</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.	
10. CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AT HOME</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>CAROLINE</b>		13c. CITY OR TOWN <b>DENTON</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Fuchs</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minna Marie Rieck</b>		16. SOCIAL SECURITY NO. <b>216749701</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216749701</b>		17. INFORMANT ADDRESS <b>Minna Fuchs, Denton, Maryland 21629</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Seizure disorder</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebral palsy</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b> <b>@ birth</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/87</b> to <b>Current</b> , 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Andrea Allen</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/7/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANDREA ALLEN MD</b>		22e. ADDRESS <b>Box 660 DENTON MD 21629</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-10-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>JR. ORDER U.A.M.</b>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>PRESTON CAROLINE MD</b>	
24. FUNERAL DIRECTOR NAME <b>MOORE FUNERAL HOME DENTON MD.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

05388 1005



071902 NOV 16

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 33531

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Harry L. German</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-07-87</b>		2b. HOUR <b>11:40 AM</b>					
3. SEX <b>male</b>		4. RACE <b>caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 20, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>80</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.				
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>broker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>real estate</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Talbot</b>		13c. CITY OR TOWN <b>Easton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>307 S. Harrison St./21601</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN A. GERMAN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DOLLIE PHILLIPS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>W.W. 11 173-07-7129</b>		17. INFORMANT <b>Howard N. German, Jr.</b>			ADDRESS <b>Easton, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis state</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Colonic ischemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Diffuse Alveolar Septic Process 10-15 yrs</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b> <b>1-2 months</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>End stage renal Disease, Hypertension</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <b>FEB</b> , 19 <b>85</b> , to <b>Nov 7</b> , 19 <b>87</b> , that (we) last saw the deceased alive on <b>Nov 7</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Lawrence D. Bohan MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-7-87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LAWRENCE D. BOHAN MD</b>			22e. ADDRESS <b>Easton, Md. 21601</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>11-8-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Salisbury Crem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury, Wicomico, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>			ADDRESS <b>Easton, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 13 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

BP

SECRET

SECRET

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 3 3 5 3 2

REG. NO.

1- FOR  
STATE  
REGISTRAR

12 8 1 7 NOV 24 87

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Althea W. Hallock			2a. DATE OF DEATH MONTH DAY YEAR November 20, 1987		2b. HOUR A M 3:40 A				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 03 02 18		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10. CITY OR TOWN OF DEATH Oxford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 104 Myrtle Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Press Planner		12b. KIND OF BUSINESS OR INDUSTRY Printing Co.	
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Oxford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 104 Myrtle Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Pearly Wagg			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa Jordan						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (# YES, GIVE WAR OR DATES) 370-03-4842		17. INFORMANT ADDRESS Homan F. Hallock Rt 1 Box 18 Oxford MD 21654					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LUNG CANCER</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo	
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED [ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2]			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/19</u> , 19 <u>87</u> , to <u>11/20</u> , 19 <u>87</u> , that (he) (we) lost saw the deceased alive on <u>11/19</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.									
22b. SIGNATURE <u>Stephen P. Carney</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-20-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.						22e. ADDRESS Rt 3 Box 106 Easton, MD 21601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 11/20/87		23c. NAME OF CEMETERY OR CREMATORY Salisbury Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico MD		
24. FUNERAL DIRECTOR NAME Newnam Funeral Home						ADDRESS Easton, MD		25a. DATE REC'D. BY REGISTRAR NOV 23 1987	
						25b. REGISTRAR'S SIGNATURE Julia Davidson-Pedersen			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. Page 1 shows day injury, or other traumatic event, the medical examiner, which he notified at once. (IMPORTANT: If item 21 is marked or item 18 shows day injury, or other traumatic event, the medical examiner, which he notified at once.)

237

18770000180

18770000180

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRARDECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

LENA

E.

HARRISON

2a. DATE OF DEATH MONTH DAY YEAR  
November 10, 1987

2b. HOUR

6:15 A.M.

3 SEX

Female

4 RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR  
01 05 12

6 AGE (IN YEARS LAST BIRTHDAY)

75

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Talbot

MD.

10 CITY OR TOWN OF DEATH

Easton

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Meridian Nursing Center-The Pines

12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Homemaker

12b. KIND OF BUSINESS OR INDUSTRY

13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Talbot

13c. CITY OR TOWN

Easton

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

622 South Street 21601

14 FATHER'S NAME

Samuel

15 MOTHER'S MAIDEN NAME

Mary

Elizabeth

Collison

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

no

16b. SOCIAL SECURITY NO.

217-09-7499

17 INFORMANT

Hans H Schwarten Rt 1 Box 72 Cordova MD 21625

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory and cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Repeated cerebrovascular accidents

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (g)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/13 19 87 to 11/11 19 87, that (I) (we) last saw the deceased alive on 10/13 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

11-11-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

MD Crowley MD

22e. ADDRESS

Easton, MD

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

11/12/87

23c. NAME OF CEMETERY OR CREMATORY

Spring Hill Cemetery

23d. LOCATION  
CITY OR TOWN

Easton

COUNTY

Talbot

STATE

MD

24. FUNERAL DIRECTOR

NAME

Newnam Funeral Home

ADDRESS

Easton, Maryland

25a. DATE REC'D. BY REGISTRAR

NOV 12 1987

25b. REGISTRAR'S SIGNATURE

Julia Friedman-Paine

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

71804 10013 61



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*[Faint, illegible handwritten text]*

073785 DEC-30

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE

338709

FOR  
STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

CHARLES

ALAN

HOWARD

1. SEX

Male

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR  
07 02 33

6. AGE (IN YEARS)

(LAST BIRTHDAY)  
54 YRS.

IF UNDER 1 YR.

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

2a. DATE KNOWN  
OF DEATH ESTI-  
MATEDMONTH DAY YEAR  
☒ 11 28 19877b. HOUR  
1:15 P<sub>M</sub>2c. DATE  
PRONOUNCED  
DEADMONTH DAY YEAR  
11 28 19872d. HOUR  
2:45 A<sub>M</sub>7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Talbot

MD.

10. CITY OR TOWN OF DEATH

Royal Oak

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Winson Farm - Ferry Neck Road

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

Waterman

12b. KIND OF BUSINESS  
OR INDUSTRY

Seafood

13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Talbot

13c. CITY OR TOWN

Royal Oak

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

Deep Neck Road

21662

14. FATHER'S NAME

FIRST  
Joseph

MIDDLE

Nelson

LAST

Howard Sr

15. MOTHER'S MAIDEN NAME

FIRST  
Emma

MIDDLE

Rose

LAST

Duvall

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

yes

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

1954-1956

17. INFORMANT

219-28-4041

Nancy E Howard P O Box 205 Royal Oak MD

21662

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

(b) Coronary heart disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

minutes

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR  
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion  
death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.ACTUAL  
SIGNATURE

Reinhardt Sahmel

TITLE (SPECIFY)

M.D. Deputy MEDICAL EXAMINER

DATE  
SIGNED

11/30/87

EXAMINER'S NAME  
(TYPE OR PRINT)

Reinhardt Sahmel

ADDRESS

Lab, Memorial Hospital, Easton, MD

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial

23b. DATE

12/1/87

23c. NAME OF CEMETERY OR CREMATORY

Oxford Cemetery

23d. LOCATION  
CITY OR TOWN

Oxford

COUNTY

Talbot

STATE

MD

24. FUNERAL DIRECTOR  
NAME

Newnam Funeral Home

ADDRESS

Easton, Maryland

25a. DATE REC'D. BY REGISTRAR

DEC 02 1987

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Pendleton

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. THIS CERTIFICATE IS VALID FOR 30 DAYS. IF THE  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH THIS PAGE. RETAIN PAGE 3 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

638825

NO 217850

RECEIVED 10/11/71

01/10/71

10/11/71



10/11/71



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

072751 NOV 23 87

1. DECEASED NAME (TYPE OR PRINT)		FIRST Dorothy		MIDDLE M.	LAST Kelly	2a. DATE OF DEATH MONTH DAY YEAR November 18, 1987		2b. HOUR 9:39 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 08 26 14		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10. CITY OR TOWN OF DEATH Oxford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Brightwaters Farm		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Oxford		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Brightwaters Farm 21654	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Clark Morrell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna H. Ranck		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 100-05-1126		17. INFORMANT ADDRESS Roger M. Kelly P O Box 10 Oxford MD 21654	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PROGRESSIVE ACUTE RENAL FAILURE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MONTHS</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____		
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>RECENT CEREBROVASCULAR ACCIDENT</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <u>4/11</u> , 19 <u>65</u> , to <u>11/18</u> , 19 <u>87</u> , that (2) we last saw the deceased alive on <u>11/18</u> , 19 <u>87</u> , and that in (3) our opinion death occurred on the date and hour and from the causes stated above (4) we did (did not) view the body after death.			
22b. SIGNATURE <u>Ludwig Eglseider, III, M.D.</u>		22c. DATE SIGNED <u>11/19/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
Ludwig Eglseider, III, M.D.		Rt 3 Box 106 Easton MD 21601	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/21/87		23c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Oxford Talbot MD	
24. FUNERAL DIRECTOR NAME ADDRESS Newnam FUneral Home Easton, Maryland				25a. DATE REC'D. BY REGISTRAR NOV 20 1987		25b. REGISTRAR'S SIGNATURE <u>John Swiden Randle</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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NOV 30 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon patient's copy. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 3 3 5 3 5

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edward Haynes Kelly			2a. DATE OF DEATH MONTH DAY YEAR November 8, 1987		2b. HOUR 2:00 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 03 08 08		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.	
10. CITY OR TOWN OF DEATH Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) William Hill Health Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive		12b. KIND OF BUSINESS OR INDUSTRY Textile
13a. STATE Maryland	13b. COUNTY Talbot	13c. CITY OR TOWN Trappe	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt 2 Box 128 21673
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Edward Kelly		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Kennedy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 089-03-5616		17. INFORMANT ADDRESS Ann K White Rt 2 Box 128 Trappe MD 21673	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONIA</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48h
DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>BULBAR Palsy</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/29 87</u> to <u>11/8 87</u> , that (I) (we) lost saw the deceased alive on <u>10/29 87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Ludwig J. Edlseder, III, M.D.</u>		DEGREE		22c. DATE SIGNED 11/9/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ludwig J. Edlseder, III, M.D.		22e. ADDRESS Rt 3 Box 106 Easton, MD 21601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/18/87	23c. NAME OF CEMETERY OR CREMATORY Buffalo Presbyterian Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Greensboro Guilford NC	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		ADDRESS Easton MD 21601		25a. DATE REC'D. BY REGISTRAR NOV 13 1987	
				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

0-8171-6021-0

072632 NOV 20 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Della P. Kingsbury</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11 7 87</i>		2b. HOUR <i>10A</i> M	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 12, 1888</i>		
6. AGE (IN YEARS LAST BIRTHDAY) <i>99</i> YRS.		7. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		13. STREET ADDRESS <i>P.O. Box 35</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Robison Parrott</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lottie Parrott</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i>		
17. INFORMANT <i>Lillian Gupton</i>		18. SOCIAL SECURITY NO. <i>222-14-1450</i>		19. ADDRESS <i>Marydel, MD</i>		
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest / respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Dementia, Refusal to eat, malnutrition, fracture left humerus</i>						
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>10/30 87</i> P.M. <i>19</i>		21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21g. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE <i>11/7 87</i>		
22. I certify that (I) (this hospital) attended the deceased from <i>10/30 87</i> to <i>11/7 87</i> , that (I) (we) last saw the deceased alive on <i>11/6 87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>M.D. Crowley</i>		22c. DEGREE <i>MD</i>		22d. DATE SIGNED <i>11.7.87</i>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>M.D. Crowley, M.D.</i>		22f. ADDRESS <i>Easton, MD</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11-10-87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greensboro Cemetery</i>		
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Greensboro CA MD</i>		24. FUNERAL DIRECTOR NAME ADDRESS <i>John E. Boulais Greensboro, MD</i>				
25. DATE RECEIVED BY REGISTRAR <i>NOV 13 1987</i>		26. REGISTRAR'S SIGNATURE <i>Julia Tidwell-Pandora</i>				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The deceased's carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

1500 1500

072750 NOV 23 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

7 3 3 5 3 7

1. DECEASED NAME (TYPE OR PRINT) FIRST Mabel E LAST Leonard			2a. DATE OF DEATH MONTH DAY YEAR 11-17-1987		2b. HOUR 3:20 P.M.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 29 00		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD				
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School teacher		12b. KIND OF BUSINESS OR INDUSTRY Education			
13a. STATE Maryland			13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 108 N. Higgins Street 21601	
14. FATHER'S NAME FIRST MILES MIDDLE ANDREW LAST DICKERSON			15. MOTHER'S MAIDEN NAME FIRST MARGARET MIDDLE MAE LAST DILLON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-42-0990		17. INFORMANT ADDRESS Elaine McWhorter 108 N Higgins St Easton MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Recent (Druid) cerebral thrombosis + coronary atherosclerosis</u>										
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) —					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — —					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/14</u> , 19 <u>87</u> , to <u>11/17</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/17</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <u>Robert T. Dawkins Jr.</u>			DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/18/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROBERT T. DAWKINS JR.</u>			22e. ADDRESS <u>EASTON 508 2 D S W L D RD 21601</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/20/87		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Easton Talbot MD			
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, Maryland		25a. DATE REC'D. BY REGISTRAR NOV 20 1987		25b. REGISTRAR'S SIGNATURE <u>John E. Anderson</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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0121-1130

11-11

NOV 20 1981



1. DECEASED NAME (TYPE OR PRINT) <b>Jeannette Saddler</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11-5-87</b>		2b. HOUR <b>3:40 M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 8, 1908</b>	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.	
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) <b>Memorial Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Postal Clerk (ret)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US Post Office</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Queen Anne's</b>		13c. CITY OR TOWN <b>Grasonville</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Carey --- Saddler</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mina --- Bryan</b>		16. SOCIAL SECURITY NO. <b>218-05-9067-B</b>	
17. INFORMANT <b>Nephew</b>		18. ADDRESS <b>R.D. 1, Box 131A</b>		19. NAME <b>Joseph B. Saddler, Jr., Queenstown, Md. 21658</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DIFFUSE INTERSTITIAL PNEUMONITIS</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/5 87</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/4 87</b> to <b>11/5 87</b> , that (I) (we) last saw the deceased alive on <b>11/4 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Stephen P. Carney</b>		22c. DATE SIGNED <b>11-5-87</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen P. Carney, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 8, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chesterfield Cemetery</b>	
24. FUNERAL DIRECTOR NAME <b>James H. Barton, Jr., Centreville, Md. 21617</b>		25. DATE REC'D BY REGISTRAR <b>NOV 12 1987</b>		26. REGISTRAR'S SIGNATURE <b>Julia Jackson-Ridgeway</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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BP

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a description of the methods used in the study. This includes a description of the experimental design, the data collection methods, and the statistical methods used to analyze the data. The third part of the report is a description of the results of the study. This includes a description of the data, a discussion of the results, and a conclusion. The fourth part of the report is a bibliography of the references used in the study.

2. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a description of the methods used in the study. This includes a description of the experimental design, the data collection methods, and the statistical methods used to analyze the data. The third part of the report is a description of the results of the study. This includes a description of the data, a discussion of the results, and a conclusion. The fourth part of the report is a bibliography of the references used in the study.

071392 NOV 10 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

33539

1- FOR  
STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)

Marguerite

A.

Molnar

2a. DATE KNOWN OF DEATH ☒ MONTH DAY YEAR  
ESTIMATED ☐ 11-5 19 87 2b. HOUR 11  
3 p.m.

3 SEX

Female

4. RACE

White

5. DATE OF BIRTH

03

21

21

6. AGE (IN YEARS)

66

YRS.

IF UNDER 1 YR.

MONTHS

DAYS

IF UNDER 24 HRS.

HOURS

MIN.

7c. DATE

PRONOUNCED DEAD

MONTH DAY YEAR

11-5 19 87

2d. HOUR

11

3 p.m.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Talbot

MD.

10. CITY OR TOWN OF DEATH

Easton

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Manager

12b. KIND OF BUSINESS OR INDUSTRY

Hotel

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Talbot

13c. CITY OR TOWN

Queen Anne

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

Rt 1 Box 97

21652

14. FATHER'S NAME

FIRST William

MIDDLE N.

LAST Allender

15. MOTHER'S MAIDEN NAME

FIRST Marguerite

MIDDLE

LAST Smith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)

no

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

17. INFORMANT

220-07-4695

ADDRESS

MD

Beverly A Platzke Rt 1 Box 97 Queen Anne

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Atherosclerotic Cardiovascular Disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

minutes

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

Hypertension, Diabetes

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opiniondeath resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Ludwig J. Eglseider III, M.D.

TITLE (SPECIFY)

Deputy

MEDICAL EXAMINER

DATE SIGNED 11-5-87

EXAMINER'S NAME

(TYPE OR PRINT)

Ludwig J. Eglseider III, M.D.

ADDRESS Rt. 3, Box 106, Easton, Md. 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

11/9/87

23c. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cemetery

23d. LOCATION

CITY OR TOWN

Brooklyn

COUNTY

Baltimore

STATE

MD

24. FUNERAL DIRECTOR

NAME

Newnam Funeral Home

ADDRESS

Easton, Maryland

DATE RECEIVED BY REGISTRAR

NOV 9 1987

SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, AND 3. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

NOV 10 1965

EX-100 COTTON FIBRE

WILSON

NOV 10 1965

071904 NOV 16 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove and deposit in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 33540

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William Owen Murden</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11 7 87</i>			2b. HOUR <i>1:30</i> AM		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>01 06 27</i>		6. AGE (IN YEARS (LAST BIRTHDAY)) <i>60</i> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>TALBOT</i> MD.		
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Buyer/Sales</i>		
12b. KIND OF BUSINESS OR INDUSTRY <i>Shoes</i>		13a. STATE <i>Maryland</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>St Michaels</i>		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>Rt 1 Box 489 21663</i>						
14. FATHER'S NAME FIRST MIDDLE LAST <i>William B. Murden</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Katherine C. Lang</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <i>yes</i>		16b. SOCIAL SECURITY NO. <i>WW II 216-20-1438</i>		17. INFORMANT ADDRESS <i>Dorothy Murden Rt 1 Box 489 St Michaels MD</i>				
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 H.R.</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <i>Pulmonary embolism secondary to deep vein thrombosis</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>4</i> 19 <i>87</i> to <i>11</i> 19 <i>87</i> that (I) (we) last saw the deceased alive on <i>June 19 87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>11/11/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Memorial Pk</i>		
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Easton Talbot MD</i>		23e. DATE REC'D. BY REGISTRAR <i>NOV 13 1987</i>						
23f. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>								
24. FUNERAL DIRECTOR NAME ADDRESS <i>Newnam Funeral Home Easton, Maryland</i>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. Page 4 should be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

DHMH - 16 60M 7/B4  
(VIA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 33541

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Paul W. Newcomb</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 16 1987</b>			2b. HOUR <b>10:10 AM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08 11 96</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.			
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner/Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Steel Company</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Talbot</b>		13c. CITY OR TOWN <b>Oxford</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Rt 1 Sailors Retreat 21654</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Adrian Newcomb</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lorell Bateman</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>unknown</b>		17. INFORMANT ADDRESS <b>Pauline Storer Mountain Lake Lake Wales FL 33853</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic heart disease</b> Uncertain DUE TO, OR AS A CONSEQUENCE OF (c) <b>Uncertain</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>&lt;12 hrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Multi-infarct dementia</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11-22</b> , 19 <b>83</b> , to <b>11-16</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>11-16</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Robert Trever, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11-16-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert Trever, M.D.</b>				22e. ADDRESS <b>RD 3 Box 297 Easton, Md. 21601</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/19/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cedarville Cumberland NJ</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Newnam Funeral Home Easton, Maryland</b>				25a. DATE REC'D BY REGISTRAR <b>NOV 19 1987</b>					
				25b. REGISTRAR'S SIGNATURE <b>Julia Denton-Randall</b>					

SECTION 10000

NOV 10 1961



072749 NOV 23 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JANE B. T. PITMAN			2a. DATE OF DEATH MONTH DAY YEAR 11-17-87			2b. HOUR 10 <sup>30</sup> AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 07 07 12			6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.		
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Financial Secretary			12b. KIND OF BUSINESS OR INDUSTRY Tea Company	
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2 Colonial Court 21601	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur A. Thomas		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Bartlett			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				
16b. SOCIAL SECURITY NO. 035-03-5589		17. INFORMANT Stephen M. Pitman, IV				ADDRESS Havelock, N.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left lower lobe Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>3 days</u> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Refractory Pneumonia with Exan Plasts (Acute Non hemolytic leukinemia)</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11/15</u> 19 <u>1978</u> , to <u>11/17</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/17</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Wm H Wood Jr		DEGREE MD		ATTENDING PHYSICIAN MEDICAL DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11/17/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm H Wood Jr		22e. ADDRESS EASTON Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11/19/87		23c. NAME OF CEMETERY OR CREMATORY Salisbury Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico MD			
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		ADDRESS Easton, Maryland		NOV 20 1987					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

073711 1013

*Handwritten signature*

1013 073711

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Arnita I. Purnell</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>7</b> YEAR <b>87</b>		2b. HOUR <b>8:45</b> AM
3. SEX <b>Female</b>	4. RACE <b>BLK</b>	5. DATE OF BIRTH MONTH <b>02</b> DAY <b>23</b> YEAR <b>24</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.	
10. CITY OR TOWN OF DEATH <b>Easton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD</b>		13b. COUNTY <b>Talbot</b>	13c. CITY OR TOWN <b>Easton</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>8 Hopkins Place</b>
14. FATHER'S NAME FIRST <b>Alexander</b> MIDDLE <b>Price</b> LAST <b>Price</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Lothie</b> MIDDLE <b>Stanley</b> LAST <b>Stanley</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216 16 7870</b>		17. INFORMANT <b>Emily Purnell</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severe Chronic Obstr. Pulm. Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Cerebral dysfunction due to overdose of oral theophylline. Morbid obesity</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <b>87</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>16/77 87</b> to <b>11/6 87</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/6 87</b> to <b>11/6 87</b> , that (I) (we) last saw the deceased alive on <b>11/6 87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>M. Crowley</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11.7.87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MD Crowley</b>		22e. ADDRESS <b>Easton, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/13/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Paradise Cemetery</b>	
24. FUNERAL DIRECTOR NAME <b>Dashell</b> ADDRESS <b>31 Gowrie St</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Trappe TA MD</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1987</b>	
		25b. REGISTRAR'S SIGNATURE <b>Frederick P. ...</b>			

072005 NOV 17 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

15000 10150

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JAMES W. ROE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 16 87</b>		2b. HOUR <b>8:20 AM</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>02 03 22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65 YRS.</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>	8. IF UNDER 24 HRS HOURS MIN. <b>0 0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.			
10. CITY OR TOWN OF DEATH <b>Easton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales representative</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bottled gas</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Talbot</b>	13c. CITY OR TOWN <b>Easton</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>5 Judas Street 21601</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Lee Roe</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel Mae Cheezum</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT ADDRESS <b>Margaret E Roe 5 Judas St Easton MD 21601</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>ANEMIA</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>10/27</b> 19 <b>87</b> to <b>11/16</b> 19 <b>87</b> , that (1) (we) lost saw the deceased alive on <b>11/3</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) not view the body after death.							
22b. SIGNATURE <b>Ludwig J. Eglseder, III, M.D.</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/17/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ludwig J. Eglseder, III, M.D.</b>				22e. ADDRESS <b>RT 3 Box 106 Easton MD 21601</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/18/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Easton Talbot MD</b>	
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>				ADDRESS <b>Easton, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 19 1987</b>	
25b. REGISTRAR'S SIGNATURE <b>Julia D. [Signature]</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Handwritten text at the bottom left corner, possibly a signature or date.

071589 NOV 12 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 - 3 3 5 4 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Thomas</u> MIDDLE <u>William</u> LAST <u>SWANN</u> <u>Thomas W. SWANN</u>			2a. DATE OF DEATH MONTH <u>November</u> DAY <u>4</u> YEAR <u>1987</u>		2b. HOUR <u>4 15</u> M.
3. SEX <u>Male</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH <u>May</u> DAY <u>2</u> YEAR <u>1906</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>81</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>TAIbot</u> MD.	
10. CITY OR TOWN OF DEATH <u>EASTON</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Memorial Hospital</u>		12a. USUAL OCCUPATION <u>Highway Maintenance Worker (ret.)</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>State Highway Adm.</u>
13a. STATE <u>Maryland</u>	13b. COUNTY <u>Queen Anne's</u>	13c. CITY OR TOWN <u>Centreville</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <u>Tilghman Terrace, 104 Tilghman Ave., 21617</u>	
14. FATHER'S NAME FIRST <u>John</u> MIDDLE <u>Franklin</u> LAST <u>Swann</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Annie</u> MIDDLE <u>Virginia</u> LAST <u>Chance</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>		16b. SOCIAL SECURITY NO. <u>WW II</u>		17. INFORMANT <u>Son</u> ADDRESS <u>6456 Harthorn Ave. Baltimore, Md. 21227</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperosmolar coma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>diabetes mellitus + uremia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH } <u>Uncertain</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Multiple cerebral infarcts</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>Oct 19</u> 19 <u>87</u> , to <u>Nov 4</u> 19 <u>87</u> , that (1) (we) most saw the deceased alive on <u>11-4</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>Robert W. Trever, M.D.</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>11-04-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robert W. Trever, M.D.</u>		22e. ADDRESS <u>RD 3 Box 297 Easton, Md. 21601</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Nov. 6, 1987</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Centreville, Q.A. Co.</u>
24. FUNERAL DIRECTOR NAME <u>James H. Barton, Jr., Centreville, Md. 21617</u>		BY <u>James H. Barton, Jr.</u> REGISTRAR			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_



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072695 NOV 23 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES. ROGERS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-29-87</b>			2b. HOUR <b>6 15 A M</b>				
3. SEX <b>Male</b> xxx <del>xxxx</del>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 12 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland Essex</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.				
10. CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Labor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>				
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Carline</b>		13c. CITY OR TOWN <b>Marydel</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Rt 1 Box 197 21649</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>216-36-9681</b>		17. INFORMANT ADDRESS <b>Helen Monore Rt 1 Box 197 Marydel Md.</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **CARDIAC ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4 P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4 P.M. 10/29/87</b> to <b>29 OCT 87</b> , that (I) (we) last saw the deceased <b>above</b> , (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Andrew McCarty</b>				DEGREE <b>ATTENDING PHYSICIAN</b>		22c. DATE SIGNED <b>2 NOV 87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANDREW MCCARTY</b>				22e. ADDRESS <b>EASTON MEMORIAL HOSPITAL</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-2--87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Marydel Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Eric DeSiell P.O. Box 606 Easton Md. 21601</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 20 1987</b>			
				25b. REGISTRAR'S SIGNATURE <b>Julia Sanders-Randall</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

2. DECEASED NAME (TYPE OR PRINT) Presson Scott Shane			2a. DATE OF DEATH MONTH DAY YEAR November 10, 1987			2b. HOUR 7:40 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 02 02 20		6. AGE (IN YEARS (LAST BIRTHDAY)) 67 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route 5, Box 737		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Chemical	
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Walter S. Shane		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Presson		13e. STREET ADDRESS Route 5 Box 737		21601	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Emily B Shane Rt 5 Box 737 Easton MD 21601			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TRANSITION CELL CANCER OF KIDNEY</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mo
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>11/10</u> 19 <u>87</u> to <u>11/10</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/10</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Stephen P. Carney</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.				22e. ADDRESS Route 3, Box 106, Easton, Maryland 21601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11/11/87		23c. NAME OF CEMETERY OR CREMATORY Salisbury Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico MD	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton, Maryland		25a. DATE REC'D. BY REGISTRAR NOV 12 1987	
						25b. REGISTRAR'S SIGNATURE <u>Lisa R. ...</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Rufus Oliver Stinchcomb</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 20 87</b>			2b. HOUR <b>10:45 A M</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 5 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot County</b> MD				
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self Employed</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Talbot</b>		13c. CITY OR TOWN <b>Tilghman Il.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Chicken Point Road 21671</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Stinchcomb</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Ellen Wood</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17. INFORMANT <b>Daughter</b>		ADDRESS <b>101 Ferdinand Ave. Glen Burnie, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>suspected acute myocardial infarct</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ischemic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>11-20</b> , 19 <b>87</b> , to <b>11-20</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>11-20</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>R. Sanchez M.D.</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>11-20-87</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS <b>508 Edgewood Ave Easton</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 23, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. Md</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>Singleton Funeral Home, Glen Burnie, Md.</b>				25a. DATE REG'D BY REGIS. <b>NOV 24 1987</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

67 33549

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Hilda Marie Taylor			2a. DATE OF DEATH MONTH DAY YEAR November 15, 1987			2b. HOUR PM		
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR July 24, 1915		
6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.			7. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home			13. STREET ADDRESS MD Route 404 21629		
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Dunn Hall			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Maggie Todd			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
17. SOCIAL SECURITY NO. 214184243			18. INFORMANT Louise Dickerson, Elkton, MD			19. DATE OF OPERATION		
20. CONDITION FOR WHICH OPERATION WAS PERFORMED			21a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			22. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
23. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			24. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			25. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
26. INJURY OCCURRED			27. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			28. LOCATION STREET CITY OR TOWN COUNTY STATE		
29. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.			30. DATE SIGNED			31. DATE SIGNED		
32. SIGNATURE William J. Banfield			33. DEGREE MD			34. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
35. PHYSICIAN'S NAME (TYPE OR PRINT) William J. Banfield, M.D.			36. ADDRESS Easton, Md. 21601			37. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		
38. DATE 11/19/87			39. NAME OF CEMETERY OR CREMATORY Denton Cemetery			40. LOCATION CITY OR TOWN COUNTY STATE Denton, Caroline MD		
41. FUNERAL DIRECTOR NAME Moore Funeral Home			42. ADDRESS Denton, Md. 21629			43. DATE RECEIVED BY REGISTRAR NOV 24 1987		
44. REGISTRAR'S SIGNATURE John Dickerson-Randall			45. REGISTRAR'S SIGNATURE			46. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days years
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic asthmatic bronchitis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. The funeral director should then return the certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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NOV 27 1987

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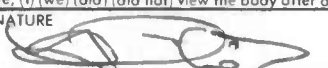
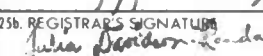


072012 NOV

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 3 3 5 5 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Sarah J. Thomas</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 7 87</b>		2b. HOUR <b>10<sup>05</sup> AM</b>				
3. SEX <b>Female</b>		4. RACE <b>BLK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 11 06</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.			
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>Talbot</b>		13c. CITY OR TOWN <b>Easton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>24 Thoroughgood Ln</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Noah</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ardele</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>206-20-3804</b>		17. INFORMANT ADDRESS <b>Casper</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Massive Intraabdominal Adenocarcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/2/87</b> 19 to <b>11/7/87</b> 19, that (I) (we) last saw the deceased alive on <b>11/7/87</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/8/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>L. Thomas Divilio, M.D.</b>				22e. ADDRESS <b>404 Marvel Ct Easton, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/12/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Paradise Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Trappe TA MD</b>			
24. FUNERAL DIRECTOR NAME <b>George Dastie</b>				ADDRESS <b>1131 Towrest Easton MD</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1987</b>		25b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 3 3 5 5 1

REG. NO.

1. DECEASED NAME (Type or Print)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST JULIA E. THORPE		MONTH DAY YEAR 10-29-87		12 40 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE	B	MONTH DAY YEAR 11 31 1922		64 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
PA	U.S.			TALBOT MD	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
EASTON	MEMORIAL HOSPITAL		Retired		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE	
MD	TAL	EASTON		701 Doverbrook Apt. 697	
14. FATHER'S NAME (Type or Print)		15. MOTHER'S MAIDEN NAME (Type or Print)			
HARRY DOBSON		DAISY DOBSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR DATE)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Type or Print)	
NO		66-22-0203		Cythia Welby - Balt. MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). Part I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Systemic effect of adenocarcinoma of sigmoid colon</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Paraplegic due to spinal cord injury, A&amp;V D</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>83</u> to <u>10/29</u> , 19 <u>87</u> , that (I) (we) lost <u>saw the deceased alive on 10/29</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>MDC Crowley</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10-30-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MDC Crowley</u>		22e. ADDRESS <u>508 Idlewild Avenue, Easton, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
B	11/2/87	Unmarked		Easton Tal MD	
24. FUNERAL DIRECTOR (NAME)		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Eric D. Dashiell		NOV 10 1987		<u>Eric D. Dashiell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be left blank.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completed and filed in the funeral director's office. It should be detached for use on the burial-transit permit. Please remove carbon papers before filing. It should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified upon receipt.)

BP

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 7 3 3 5 5 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN E. CREIGHTON TRAVERS</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11 26 87</b>		2b. HOUR <b>4 40 P M</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUC.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOV. 27, 1902</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Towson</b> MD.			
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CRAB PICKER</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>SHELLFISH</b>		13a. STATE <b>MARYLAND</b>			
13b. COUNTY <b>DORCHESTER</b>		13c. CITY OR TOWN <b>FISHING CREEK</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
13e. STREET ADDRESS <b>BOX 38</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN E. CREIGHTON</b>			
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARTHA CREIGHTON</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>212-16-1425</b>		17. INFORMANT ADDRESS <b>205 SANDY HILL ROAD, CAMBRIDGE MD. 21613</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Cerebral Vascular Accident</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/27 1987</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>11/22 1987</b> to <b>11/26 1987</b> , that (II) we last saw the deceased alive on <b>11/26 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not follow the body after death.			
22b. SIGNATURE <b>Donald Lewers M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11/26/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Donald Lewers, M.D.</b>		22e. ADDRESS <b>Easton, Md. 21601</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11-29-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DOR.MEM.PK. CEME</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>CAMBRIDGE, DORCHESTER, MD.</b>		24. FUNERAL DIRECTOR NAME <b>Curran Funeral Home</b>			
24. ADDRESS <b>Cambridge, Md. 21613</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 30 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (page 1) and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME <small>(Type or Print)</small> FIRST MIDDLE LAST MARY F. WALKER			2a. DATE OF DEATH MONTH DAY YEAR 11-8-87		2b. HOUR 705P <sup>M</sup>
3. SEX Female	4. RACE Blk	5. DATE OF BIRTH MONTH DAY YEAR 6 6 08		6. AGE (IN YEARS LAST BIRTHDAY) 79	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE <small>(STATE OR FOREIGN COUNTRY)</small> MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD		
10. CITY OR TOWN OF DEATH EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <small>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</small> MEMORIAL HOSPITAL		12a. USUAL OCCUPATION <small>(TYPE OF WORK FOR MOST OF WORKING LIFE)</small> Domestic	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY Talbot	13c. CITY OR TOWN St Michaels	13d. STREET ADDRESS Hampton Village 21663	
14. FATHER'S NAME FIRST MIDDLE LAST William Murray		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Shirley Lawrence Smathers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <small>(YES, NO OR UNKNOWN)</small> +		16b. SOCIAL SECURITY NO. 213-01-1093		17. INFORMANT Shirley Smathers	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>a</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(IF EITHER, NOTIFY MEDICAL EXAMINER)</small>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY <small>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)</small>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>11-7</u> , 19 <u>87</u> , to <u>11-8</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11-8</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23. SIGNATURE <u>Lawrence D. Bohan MD</u>		DEGREE MD		22c. DATE SIGNED 11-8-87	
24. PHYSICIAN'S NAME (TYPE OR PRINT) LAWRENCE D. BOHAN MD		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL <u>1588-6447</u>		23b. DATE 11/14/87	23c. NAME OF CEMETERY OR CREMATORY Royal Oak		23d. LOCATION CITY OR TOWN COUNTY STATE Easton TA. MD.
24. FUNERAL DIRECTOR NAME ADDRESS George DeShields Funeral Home Easton, Md.		25a. DATE REC'D. BY REGISTRAR NOV 16 1987		25b. REGISTRAR'S SIGNATURE <u>W. Davidson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please give the carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MYRTLE K. WARNER			2a. DATE OF DEATH MONTH DAY YEAR November 1, 1987		2b. HOUR 11:45 A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 05 22 04		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Claiborne		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bay street		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School teacher			12b. KIND OF BUSINESS OR INDUSTRY Education			
13a. STATE Maryland		13b. CITY OR TOWN Claiborne		13c. STREET ADDRESS Bay Street 21624		
14. FATHER'S NAME FIRST MIDDLE LAST Madison Brown, Sr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Elizabeth Cray				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-82-6751		17. INFORMANT ADDRESS William J. Warner Gen. Del. Claiborne MD 21624		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) the hospital attended the deceased from <u>5 June</u> , 19 <u>87</u> , to <u>11-1</u> , 19 <u>87</u> , that (we) last saw the deceased alive on <u>31 Oct 1987</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (or I) (did) (did not) view the body after death.						
22b. SIGNATURE <u>R. Lane Wroth, M.D.</u> DEGREE				22c. DATE SIGNED <u>11-3-87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Lane Wroth, M.D.				22e. ADDRESS St. Michaels, Maryland 21663		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/4/87		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Pk		
23d. LOCATION CITY OR TOWN Easton		23e. COUNTY Talbot		23f. STATE MD		
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				25. DATE RECEIVED BY REGISTRAR NOV 5 1987		
25a. REGISTRAR'S SIGNATURE John Gordon Rudebeck						

MEDICAL CERTIFICATION

29

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

051014-1-201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ETHEL L. WHITE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11. 2. 87</b>		2b. HOUR <b>817P<sup>M</sup></b>
3. SEX <b>FEMALE</b>	4. RACE <b>NEGRO</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>DEC. 3, 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.	
10. CITY OR TOWN OF DEATH <b>EASTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FACTORY WORKER</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>SEAFOOD</b>	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>TALBOT</b>	13c. CITY OR TOWN <b>ST. MICHAELS</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Dawson Chester</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Virginia Holland</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-01-1501</b>		17. INFORMANT ADDRESS <b>108 FREMONT ST. ST. MICHAELS, MARYLAND 21663</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Probable MI</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>CHF, ASCVD, Metastatic Breast Ca, Diabetes Mellitus</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>George B. Lawrence MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>11-2-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George B. Lawrence MD</b>		22e. ADDRESS <b>EASTON, MARYLAND 21601</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>NOV. 7, 1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>THOMAS MEMORIAL CEM.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>ST. MICHAELS TALBOT MARYLAND</b>		
24. FUNERAL DIRECTOR NAME <b>James E. Leonard St. Michaels Md</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1987</b>	25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Pudney</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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